OFF-DUTY CIVILIAN EMPLOYMENT REQUEST

PRIVACY ACT STATEMENT: Social Security Numbers are requested under the authority of Executive Order 9397 for the purpose of identifying the requester. Disclosure is voluntary, but failure to do so may result in the delay or denial of your request.

Section A.

From: _____

(Name, rank/grade, social security number)

To: Commanding Officer, _____

Ref: (a) 5 U.S.C. sec. 5536
(b) DOD 5500.7-R
(c) HA Policy 96-050, "Policy for Off-Duty Employment by DOD Health Care Practitioners"
(d) ASD(HA) Memorandum of 23 July 1996
(e) MANMED Article 1-22

Encl: (1) Letter for appropriate professional society

1. Per references (a) and (b), I request permission to engage in off-duty employment as set forth below. Enclosure (1) is forwarded as required by reference (a).

a. My proposed employer is: _____

b. My proposed worksite is located at: _____

c. My proposed worksite telephone number is: _____

d. My proposed work hours are: _____

e. My proposed duties will include: _____

_____

_____

f. I do/do not have permission to engage in other off-duty employment (state details on separate sheet, if applicable).

2. I acknowledge the following limitations on my off-duty employment and have explained them to my proposed employer.

a. The site of my off-duty employment must be located within 2 hours travel time, by land, of the site of my military duties.

b. I must have a period of at least 6 hours between the end of my off-duty employment and the start of my military duties and must not work more than 16 hours per continuous 7-day period without specific approval of my commanding officer.

c. As part of my off-duty employment, I must not assume primary responsibility for the medical or dental care of any patient on a continuing basis.

d. My off-duty employment must not be performed on military premises; involve expense to the Federal Government; or involve use of military personnel or supplies.

e. As a military member, I may be required to respond immediately to calls for military duty, **or**

As a civilian officer equivalent healthcare provider, or contract healthcare provider, I may be required to respond immediately to calls for duty. My obligation for such recall is as follows:

_____

_____

_____

g. I am responsible for compliance with all local licensing, Federal Drug Enforcement Administration, and personal medical liability coverage requirements.

h. I must take annual leave for any obligations (e.g., court appearances or testimony before a compensation board) arising out of off-duty employment when these obligations require absence during duty hours. There is no guarantee that the leave request will be approved by my command.

i. I must not refer patients from the military treatment facility to my prospective employer's facility.

j. I must not solicit or accept a fee directly or indirectly, and my prospective employer must not charge, for my care of a Department of Defense (DOD) healthcare beneficiary (i.e., member, retired member, or dependent of such member) of the Uniformed Services. TRICARE payments shall be disallowed in any claim from a TRICARE provider in those instances when a Navy healthcare provider renders services to such a person, for the services provided by the Navy healthcare provider. This restriction does not apply to dental services provided to CONUS enrollees of the TRICARE Family Member Dental Plan. TRICARE payments for services I provide a DOD health care beneficiary during my off-duty employment shall be disallowed.

_____

Signature Date

. . . . . .

Section B.

From: Authorized Representative of Proposed Employer

To: Commanding Officer, _____

Subj: OFF-DUTY EMPLOYMENT OF _____

1. I am the authorized representative of _____

2. I have read and accept the foregoing limitations, including the compensation and availability limitations, on the off-duty employment of _____

3. I certify that this facility will not seek payment from a DOD beneficiary, TRICARE, or the Federal Government for health care provided by _____
to DOD beneficiaries except to dental services provided to CONUS enrollees of the TRICARE Family Member Dental Plan.

_____

_____

_____

(Name/Title/Date)

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Section C.

From: Commanding Officer, _____

To: _____

1. The above request is approved/disapproved.

_____

(Name/Date)